

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH



Raul Pino, M.D., M.P.H.  
Commissioner

Dannel P. Malloy  
Governor  
Nancy Wyman  
Lt. Governor

### Healthcare Quality And Safety Branch

December 19, 2018

Michael Collins, Administrator  
Manchester Memorial Hospital  
71 Haynes St  
Manchester, CT 06040

Dear Mr. Collins:

An unannounced visit was made to Manchester Memorial Hospital on November 21, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

**The plan of correction is to be submitted to the Department by January 2, 2019.**

The plan of correction shall include:

- (1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
- (2) the date each such corrective measure or change by the institution is effective;
- (3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
- (4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the



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DATE OF VISIT: November 21, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT  
STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES  
WERE IDENTIFIED

violation is not responded to by **January 2, 2019** or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Karen E. Gworek, RN  
Supervising Nurse Consultant  
Facility Licensing and Investigations Section

KEG/PT:jf

Complaint #24456

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

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1. Based on clinical record review, facility documentation and interviews for one sampled patient (Patient #1) reviewed for abuse, the facility failed to initiate an investigation upon knowledge of an alleged incident of abuse. The findings include:
  - a. Patient #1 was admitted on 10/11/18 at 12:01 PM to the ED (Hospital #2) for complaints of depression and suicidal ideation. The ED clinical record identified the patient was assessed and determined to require further behavioral health intervention. Patient #1 was transferred to Hospital #1's adolescent behavioral health unit on 10/12/18 at 5:40 PM. The clinical record identified the patient was assessed, diagnosed with unspecified depressive disorder, the treatment plan interventions included fifteen (15) minute checks for safety and observation as well as individual and group therapy. Review of the clinical record from 10/12/18 through 10/18/18 identified the facility followed their plan of care, the patient's behavior was appropriate and he/she was discharged home with outpatient behavioral health services on 10/18/18. Patient #2 was admitted to Hospital #1's adolescent behavioral health unit on 10/10/18 for diagnoses of autistic spectrum disorder and depression. The clinical record identified the patient's treatment plan interventions included fifteen (15) minute checks for safety and observation as well as individual and group therapy. Patient #2 was discharged home with outpatient behavioral health services on 10/18/18. In an interview on 11/21/18 at 11:30 AM, the behavioral health unit Clinical Nurse Manager identified a social worker, Social Worker (SW) #1, informed him that an alleged incident of inappropriate contact between Patient #1 and Patient #2 had been reported to SW #1. The Clinical Nurse Manager stated he directed SW #1 to collect more information about the allegation and report back to him. The Clinical Nurse Manager identified he did not receive any other information from SW #1. In an interview on 11/21/18 at 11:40 AM, SW #1 identified Patient #2 had social difficulties with his/her peers and that Patient #1 had voiced concerns of Patient #2's behavior towards him/her. SW #1 stated although there was no documentation the concern was discussed with staff. SW #1 identified an outside clinician informed him Patient #1 stated he/she was inappropriately touched while he/she was at Hospital #1 and a state agency had reported the incident as abuse. SW #1 identified he reported the information to the Clinical Nurse Manager and did not initiate an investigation since Patient #1 was no longer a patient, there was no reason to follow up on the allegation. In an interview on 11/21/18 at 1:30 PM, the Director of Behavioral Health identified he became aware of the alleged incident reported by Patient #1 when this surveyor notified them. The Director of Behavior Health identified upon receipt of an allegation of abuse an investigation should be initiated even if the patient is no longer at the facility.